

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

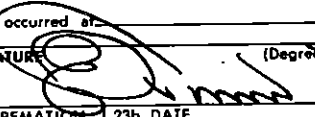
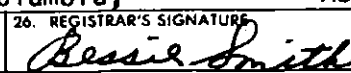
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6268 63-044176  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

<b>FILED DEC - 2 - 1963</b>	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>	<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>3yrs</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital Med. Ct.</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS (If outside, give location) <b>4225 Highland</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> First Middle Last <b>James Lewis Nunnelly</b>	
<b>4. DATE OF DEATH</b> Month Day Year <b>November 16, 1963</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>
<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-20-1879</b>
<b>9. AGE (last birthday)</b> <b>84</b>	
IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during working life, even if retired) <b>retired</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bluffton, Mo.</b>
<b>11. BIRTHPLACE</b> (City and state or country) <b>Bluffton, Mo.</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>James Nunnelly</b>	
<b>13b. MOTHER'S MAIDEN NAME</b> <b>unknown</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Anna Mae Nunnelly</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
<b>17. INFORMANT</b> Address <b>Flossie Mae Brooks 4225 Highland</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> DUE TO (b) <b>Malnutrition and dehydration</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year	
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)
<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <b>11-15-63</b> to <b>11-16-63</b> and last saw her alive on <b>11-16-63</b> Death occurred at <b>5:22 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
<b>22a. SIGNATURE</b> 	<b>22b. ADDRESS</b> <b>2400 Cherry</b>
<b>22c. DATE SIGNED</b> <b>11-18-63</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>removal</b>	<b>23b. DATE</b> <b>11-19-63</b>
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Columbia, Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Watkins Bros. Funeral Home 18th Benton</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>11-18-63</b>
<b>26. REGISTRAR'S SIGNATURE</b> 	

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

VS 300  
Rev. 4/59

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9286.5

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bruce A. Watkins

Licensed Embalmer No. 4500

P. O. Address For Benton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

8-2-84

8-2-0-1

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